JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

FACT SHEET

Report No. 424

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Mitigating the Risk of Improper Payments in the Virginia Medicaid Program

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BACKGROUND

Medicaid is the largest program in Virginia's budget, accounting for more than $7.2 billion split between state and federal funds in FY 2011. Because Medicaid is so large, even a relatively small amount of improper payments (resulting from errors, fraud, or abuse) is costly. The Department of Medical Assistance Services (DMAS) bears direct responsibility for protecting the fiscal integrity of Medicaid. To this end, DMAS partners with the Department of Social Services (DSS) and local departments of social services to carry out program integrity activities, which aim to prevent, detect, and collect payments that were made improperly.

KEY FINDINGS

Findings of the first year of this study are in the 2010 JLARC *Interim Report: Fraud and Error in Virginia's Medicaid Program*. In this year's study, we noted the following:

- About $6.1 million in costs to the state general fund was identified in FY 2009 as resulting from fraud committed by Medicaid recipients and providers.
- The eligibility determination process presents the greatest risk of improper payments being made, as evidenced by a 2009 federal review indicating that up to 17 percent of individuals who were enrolled in Virginia's Medicaid program may not have been eligible. We estimated the negative impact of the resulting improper payments on the general fund may have ranged from $18 million to $263 million.
- DMAS successfully detected 91 percent of improper payments to providers, according to a 2009 federal review.
- DMAS may be paying inflated rates to managed care organizations, which enroll and reimburse providers on DMAS' behalf for a subset of Medicaid recipients. The rates may be inflated because DMAS does not ensure that the managed care organizations are consistently detecting improper payments to providers.

SUMMARY OF SELECTED RECOMMENDATIONS

- To comprehensively address weaknesses across the Virginia Medicaid program, a special interagency task force is needed to determine the most appropriate means of minimizing the risk of improper payments.
- To reduce the risk of enrolling ineligible recipients, DMAS and DSS should increase their oversight and monitoring of local caseworkers, and provide them with increased training. The agencies should also invest in new information technologies to reduce the need to perform manual calculations.
- To improve DMAS' program integrity activities, the agency should (1) evaluate whether to implement a pre-payment audit process for services and providers that present a high risk of improper payments; (2) create a single plan to coordinate all audit activities; (3) perform additional oversight to ensure that managed care organizations consistently detect improper payments and report accurate expenditure data; and (4) institute a formal mechanism for evaluating staff and contractor audits to determine if potential fraud exists, and ensure that all cases of potential fraud are referred to the Medicaid Fraud Control Unit in the Office of the Attorney General.